STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396120	A. BLDG: 00 B. WING:	04/24/2023

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PHOEBE WYNCOTE STATE LICENSE NUMBER: 232102	208 FERNBROOK AVENUE WYNCOTE, PA 19095

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F 0000	INITIAL COMMENT Based on a Medicare/Medicaid Recertification Survey, Civil Rights Compliance Survey and State Licensure Survey, completed on April 24, 2023, it was determined that Phoebe Wyncote, was not in compliance with the requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities and the 28 PA Code, Commonwealth of Pennsylvania Long Term Care Licensure Regulations related to the health portion of the survey process.	F 0000		
F 0550 SS=D		F 0550		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: | (X6) DATE:

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

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F 0550 SS=D	Continued from page 1 483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.	F 0550	-Drainage bag was placed in dignity bag that was already in resident's room -Resident list reviewed. All other residents with a urine drainage bag have a dignity bag in use. -Nursing staff will be educated to ensure dignity bags are in use. -ADON/DON will audit monthly of (all residents with a urine drainage bag - 100%) and results will be presented in QAPI x4	Completion Date: 06/23/2023 Status: APPROVED Date: 05/18/2023

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F 0550 SS=D	Continued from page 2 §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: [illegible]	F 0550		
F 0600 SS=G		F 0600		

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F 0600 SS=G	Continued from page 3 483.12(a)(1) Free from Abuse and Neglect §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by:	F 0600	-Upon learning of fall and subsequent xray results, resident was transferred to hosp for appropriate treatment. -Nursing staff is being interviewed as to if they have ever not reported a fall and if they have ever been told by anyone not to report a fall. -Staff (min of 85%) to be re-educated on importance of immediately reporting incidents/accidents. ADON/DON/Nursing Supervisor will continue to review 24 hr report for any progress notes indicating an incident/accident has occurred. -DON/ADON will audit monthly and report findings in QAPI x4	Completion Date: 06/23/2023 Status: APPROVED Date: 05/18/2023

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F 0600 SS=G	Continued from page 4 Based on clinical record review, staff interview, review of facility policies, and review of facility documentation, it was determined that the facility failed to ensure that Resident R29 was free from neglect related to a Registered Nurse failing to immediately assess the resident after being notified of a fall sustained by the resident. Facility staff transferred the resident off the ground to the bed without an assessment from a Registered Nurse for possible injuries, causing the resident to scream with pain. The facility's failure to complete a timely assessment for Resident R29, resulted in harm, when the resident experienced pain and a delay in treatment for one of 17 residents reviewed. (Resident R29) Findings include: Review of facility policy, "Abuse Policy - Prevention, Investigation, Reporting" dated March 29, 2022, revealed that, "The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown	F 0600		

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F 0600 SS=G	Continued from page 5 source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials." Review of facility policy "Fall Management Program" last revised My 13, 2022, revealed: Definition of a Fall per the RAI Manual: Unintentional change in position coming to rest on the ground, floor or onto the next lower surface (i.e. onto a bed, chair, or bedside mat). The fall may be witnessed, reported by the resident or an observer or identified when a resident is found on the floor or ground. ... Review of facility documentation reported to the Department of Health on February 27, 2023, revealed: ... resident had a fall on 2/26/2023 at around 0500am ... Review of Resident R29's clinical record revealed that the resident was admitted to the facility on December 19, 2020, with the diagnoses of left femur (hip) fracture, Alzheimer's disease (causes the	F 0600		

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F 0600 SS=G	Continued from page 6 brain to shrink and brain cells to eventually die), dementia (usually progressive condition marked by the development of multiple cognitive deficits such as memory impairment) with severity and behavioral disturbance, muscle weakness, history of falling. Review of Resident R29's fall assessment, dated December 26, 2022, revealed that the resident was considered a moderate risk for falls. The interventions recommended included a "low bed, non-skid footwear, frequent checks, sit in visualization of staff, broad chair, chair locked." Review of Resident R29's quarterly Minimum Data Set (MDS- assessment of resident's care needs) dated February 3, 2023, revealed that the resident had a BIMS (Brief Interview of Mental Status) score of 3 which indicated that the resident was cognitively impaired. Continued review of the MDS revealed that the resident required extensive assistance for bed mobility and limited assistance with transfers and ambulation of one person.	F 0600		

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F 0600 SS=G	Continued from page 7 Review of Resident R29's care plan, dated February 6, 2023, revealed that the resident had a history of falls/injury and was unaware of safety needs. The interventions developed included half side rails to bed as enablers, encourage and assist to participate in activities or social settings that minimize the potential for falls, ensure that resident was wearing appropriate footwear while out of bed and provide slipper socks or non-skid slippers as indicated for nighttime and hourly checks. Review of nursing note dated February 26, 2023 at 7:00 a.m. [late entry] revealed "CNA (nurse aide) called to nurse resident observed laying on floor next to her bed with blankets over her, no s/s (signs and symptoms) of injury, no c/o (complaint) pain. Resident assisted back to bed. Nsg (nursing) supervisor made aware." Review of the next available nursing note dated February 26, 2023, at 1:02 p.m. revealed "Resident cried out in pain during assessment of lower extremities. Assessment revealed visually swollen b/l	F 0600		

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F 0600 SS=G	Continued from page 8 (bilateral) knees, R. (right) L (left), no bruising or erythema noted. Resident medicated for pain." The resident's physician was contacted and orders were obtained for X-ray to bilateral knees and left hip. Review of a Nursing note dated February 26, 2023 at 1:02 p.m. revealed: Resident moaning, pointing to left inner thigh, stating "it hurts". Resident cried out in pain during assessment of lower extremities. Assessment revealed visually swollen b/l knees, R>L, no bruising or erythema noted. Resident medicated for pain as per PRN order an lidocaine patches placed to b/l knee with some relief noted. Call out to [Doctor's Office], spoke with on call physician ... Order given, readback and verified for X-Ray to B/L knee and Left hip. Resident resting comfortably in chair, will continue to monitor. Continued review of nursing documentation dated February 27, 2023, at 4:10 p.m. noted that the results of the X-ray revealed left hip with acute fracture of the subcaptial left femoral (hip) neck. Orders were obtained for the resident to be	F 0600		

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F 0600 SS=G	Continued from page 9 transferred to the local hospital for evaluation. Review of nursing documentation dated March 1, 2023, revealed that the resident's daughter was informed that after investigation, the facility determined that the resident had a fall in her room that caused her hip fracture. By not having a Registered Nurse assess Resident R29 following an unwitnessed fall caused undue pain and a delay in care and treatment. Resident R29 did not have an x-ray report read until 23 hours and 10 minutes from the initial fall. The lack of assessment caused actual harm, undue pain and delay in care to Resident R29 who was diagnosed with a left femoral neck fracture. Review of physician's notes dated March 6, 2023, revealed that the resident was re-admitted to the facility after "a fall resulting in left femoral neck fractures. She had a left total hip replacement done on February 28, 2023."	F 0600		

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F 0600 SS=G	Continued from page 10 Employee E11, Nurse Aide, Witness statement dated February 27, 2023 (11pm-7am) revealed "I was doing my rounds and I hard [heard] someone screaming and I stop to listen I didn't hear anything so I kept on to the net [next] room so when I came out the room I hard [heard] screaming again but this time the nurse was out in the hall and I ask her did she hear so we start looking for where the noise was coming from so the nurse whent [sic - went] in [Resident R29] room and i was right behind her at the same time she was laying on the floor with both blankets and her baby on top of her so I start helping her up the nurse start helping me so when I try to put her all the way in the bed she start screaming more so I said your going to have to send her out she said ok the nurse walk out the room told the nurse supervision so I got [Resident R29] back in bed i finish my work so the next night well that night when i came in the nurse came to me and ask can I put [Resident R29] in bed because x Ray was about to come for	F 0600		

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F 0600 SS=G	Continued from page 11 her but never did and no i didn't say anything to the next shift i thought everyone knew because they said xray was coming." Review of a witness statement, dated February 27, 2023, by Nursing Supervisor, Employee E15, revealed "I regret that I did not immediately get up and assess the situation keeping in mind that Resident R29 was confused and may have fallen. My thinking was that she was resting and not getting up wondering through the hall and going into other residents rooms." The Registered Nurse Supervisor confirmed not assessing Resident 29 on February 26, 2023 for possible injuries after being notified of a fall sustained by the resident. Facility staff then then transfered the resident off the ground to the bed without an assessment from a Registered Nurse, causing harm to the resident who screamed out in pain and still continued to demostrate signs and symtoms of pain six hours after the fall.	F 0600		

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F 0600 SS=G	Continued from page 12 Interview on April 21, 2023, 1:45 p.m. with nurse aide, Employee E11, confirmed that she was a nurse aide assigned to Resident 29 and that she found Resident R29 wrapped up in a blanket rolled over her floor mattress and screaming for help. The resident bed was in low position, Resident R29 "complaint of her pain in her leg, there was no bleeding, bruising. I told the nurse we need to send her out." Review of a witness statement dated February 27, 2023, by Licensed Practical Nurse, Employee E9, revealed "It was around 5:00 a.m. we both went into the room; it looked like [Resident R29] may have either gotten twisted up and fell from the bed or got up to walk and got twisted. [Resident R29] does get up at night to wonder into other people's room and we have to re-direct her ...I did ROM of her legs and then she said something about her arm. I lifted up her gown to see if I could see anything unusual and did passage ROM of her arm, because she was agitated that I was touching her at all, which can be her usual behavior. Then I went to	F 0600		

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F 0600 SS=G	Continued from page 13 [Registered Nurse Supervisor, Employee E15] I told the [Registered Nurse Supervisor, Employee E15] [Resident R29] was on the floor holding her doll and with her blanket on top of her. [Registered Nurse Supervisor, Employee E15] said "were not going to consider that a fall." I went back to [Resident R29's] room and told CNA (nurse aide) that we're going to get her up and put her in the bed. [Registered Nurse Supervisor, Employee E15] did not visit the [Resident R29]. Interview on April 21, 2023, at 10:04 a.m. with Licensed Practical Nurse, Employee E9, confirmed that she was a nurse assigned to Resident 29 on night shift of February 25, 2023. Employee E9 confirmed Resident R29 was laying on stomach, and away from the floor mat on the bare floor. That she did a brief assessment and went to Registered Nurse, Supervisor, Employee R15. "I advised her that Resident R29 was found on the floor. The RN, Supervisor, Employee E15 told me that we're not doing an incident report. I went back to ROM of upper extremity/lower extremity arms and leg and	F 0600		

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F 0600 SS=G	Continued from page 14 lifted her up to standings position and transferred her to bed. I cannot give an explanation why there's no documentation in the resident's clinical record. I did not notify the coming nurse of the possible unwitnessed fall." On April 20, 2023, at 2:23 p.m. an interview was held with Nursing Home Administrator (NHA) and Director of Nursing (DON) who reported that based on the video footage, Registered Nurse Supervisor, Employee E15 did not go into the resident's room to assess the resident and failed to report the incident, investigated the allegation, and make any documentation in the clinical report of Resident 29. Interview on March 15, 2023, at 9:15 a.m. the Nursing Home Administrator (NHA) confirmed that RN Supervisor, Employee E15, was terminated for neglect related to not reporting and investigating an unwitnessed fall for Resident R29. The facility failed to ensure that Resident R29 was	F 0600		

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F 0600 SS=G	Continued from page 15 free from neglect related to a Registered Nurse failing to immediately assess the resident after being notified of a fall sustained by the resident. Facility staff transferred the resident off the ground to the bed without an assessment from a Registered Nurse for possible injuries, causing the resident to scream with pain and to continue to experience signs and symtoms of pain 8 hours after the fall incident. The facility's failure to complete a timely assessment for Resident R29, resulted in harm, when the resident experienced pain and a delay in treatment. Refer to F684 and F658 483.13 - Resident Behavior and Facility Practices, 10-1-1998 edition 28 Pa. Code 201.18 (b)(1)(e)(1) Management 28 Pa. Code 211.5(h)Clinical records 28 Pa. Code 211.11(d) Resident care policies	F 0600		

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	396120	A. BLDG: __00_____ B. WING: _____	04/24/2023

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F 0600 SS=G	Continued from page 16 28 Pa. Code 211.12(c) Nursing services 28 Pa. Code 211.12(d)(1)(3) Nursing services 28 Pa. Code 211.12(d)(3) Nursing services 28 Pa. Code 211.12(d)(5) Nursing services	F 0600		
F 0609 SS=D		F 0609		

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F 0609 SS=D	Continued from page 17 483.12(b)(5)(i)(A)(B)(c)(1)(4) Reporting of Alleged Violations §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by:	F 0609	-In addition to reportable events submitted for both R29 and R52, for "Transfer/Admission to Hospital Because of Injury/Accident", an additional event report submitted for both residents under "Patient/Resident Neglect". PB-22s submitted for E14, E15 and E9, and report submitted to PA State Board of Nursing for E9 and E15. -Reportable events submitted under "Transfer/Admission to Hosp..." reviewed for the past 12 months to ensure there was no neglect/abuse involved. None found. -All (100%) reportable events will be reviewed to ensure appropriate event type. Executive Director and DON educated regarding submitting appropriate event type for reportable events after investigation completed. -Executive Director will conduct audits monthly of all reportable events to ensure they event type is appropriate and report in QAPI x4	Completion Date: **06/23/2023** Status: **APPROVED** Date: **05/18/2023**

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F 0609 SS=D	Continued from page 18 Based on review of facility policies and documentation, clinical record reviews and interviews with staff, it was determined that the facility failed to ensure that all allegations of abuse and neglect, including injuries of unknown origin, were reported to the Administrator of the facility for two of 19 residents reviewed (Residents R29 and R52). Findings include: Review of facility policy, "Abuse Policy - Prevention, Investigation, Reporting" dated March 29, 2022, revealed that, "The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials." Review of Resident R29's clinical record revealed that the resident was admitted to the facility on December 19, 2020, with the diagnoses of left	F 0609		

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F 0609 SS=D	Continued from page 19 femur (hip) fracture, Alzheimer's disease (causes the brain to shrink and brain cells to eventually die), dementia (usually progressive condition marked by the development of multiple cognitive deficits such as memory impairment) with severity and behavioral disturbance, muscle weakness, history of falling. Review of Resident R29's fall Assessment, dated December 26, 2022, revealed that the resident was considered a moderate risk for falls. The interventions recommended included a "low bed, non-skid footwear, frequent checks, sit in visualization of staff, broad chair, chair locked." Review of Resident R29's care plan, dated February 6, 2023, revealed that the resident had history of falls/injury and was unaware of safety need. The interventions developed included half side rails to bed as enablers, encourage and assist to participate in activities or social settings that minimize the potential for falls, ensure that resident was wearing appropriate footwear while out of bed and provide slipper socks or non-skid slippers as	F 0609		

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F 0609 SS=D	Continued from page 20 indicated for nighttime, hourly cheeks. Review of a witness statement, dated February 27, 2023, by Nurse aide, Employee E11, which stated, "I was doing my rounds and I heard someone screaming and I stopped to listen I didn't hear anything so I kept on to the next room so when I came out the room I heard screaming again but this time the nurse was out in the hall and I asked her did she hear so we start looking for where the noise was coming from so the nurse went into [Resident R29] room ... she was laying on the floor with both blankets and her baby on top of her so I start helping her up the nurse start helping me so when I try to put her all the way in the bed she start screaming more so I said of the nurse walk out the room told the nurse supervisor so I got [Resident R29] back in bed." Review of a witness statement dated February 27, 2023, by Licensed Practical Nurse, Employee E9, revealed "It was around 5:00 a.m. we both went into the room; it looked like [Resident R29] may	F 0609		

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F 0609 SS=D	Continued from page 21 have either gotten twisted up and fell from the bed or got up to walk and got twisted. [Resident R29] does get up at night to wonder into other people's room and we have to re-direct her ...I did ROM of her legs and then she said something about her arm. I lifted up her gown to see if I could see anything unusual and did passage ROM of her arm, because she was agitated that I was touching her at all, which can be her usual behavior. Then I went to [Nursing Supervisor, Employee E15] I told the [Nursing supervisor Employee E15] [Resident R29] was on the floor holding her doll and with her blanket on top of her. [Nursing Supervisor Employee E15] said "were not going to consider that a fall". I went back to [Resident R29's] room and told CNA (nurse aide) that we're going to get her up and put her in the bed. [Nursing Supervisor, Employee E15] did not visit the [Resident R29]. Review a witness statement, dated February 27, 2023, by Nursing Supervisor, Employee E15, revealed "I regret that I did not immediately get up and assess the situation keeping in mind that	F 0609		

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F 0609 SS=D	Continued from page 22 Resident R29 was confused and may have fallen. My thinking was that she was resting and not getting up wondering through the hall and going into other residents rooms." Review of facility documentation submitted to the Department of Health on February 27, 2023, revealed a transfer/admission to hospital because of injury/accident report, revealed during am care, Resident R29 "was moaning, pointing to left inner thigh, "it hurts." Resident cried out in pain during assessment of lower extremities. Assessments revealed visually swollen both knees, no bruising or erythema noted. X-ray were ordered, obtained, and revealed there is an acute fracture of the sub capital left femoral (hip) neck with proximal migration of the distal fragment with no dislocation which required a surgery. After investigation, it was determined that resident had a fall on 2/26/2023 the charge nurse reported the fall to the supervisor, no incident report, or progress was written." Continued review of the documentation reported to	F 0609		

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F 0609 SS=D	Continued from page 23 the Deaprtment of Heath revealed that Resident R29 was subsequently transferred to the hospital for further evaluation. Upon discovery of the femor (hip) fracture, the facility initiated an investigation and determined that Resident R29 had a fall on February 26, 2023, at around 5:00 a.m. that was reported by the Licensed nurse, Employee E9 to the Registered Nurse Supervisor on duty Employee, E15. Employee E15 failed to assessed Resident R29 which resulted in a delay in medical treatment. Further Registered Nurse Supervisor, Employee E9 failed to investigate the fall incident, and document the fall which resulted in neglicence. The facility failed to report to the Department of Health the incident of neglect sustained by Resident R29 by Licensed Practical Nurse, Employee E9 and Registered Nurse Supervisor, Employee E15. Review of Resident R52's Quarterly MDS, dated October 4, 2022, revealed that the resident was admitted to the facility on July 28, 2020, and had	F 0609		

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F 0609 SS=D	Continued from page 24 diagnoses including dementia, seizure disorder (abnormal electrical activity in the brain), orthostatic hypotension (low blood pressure that happens when standing up from sitting or lying down), osteoporosis (a condition in which bones become weak and brittle), muscle weakness and repeated falls. Continued review revealed that the resident had a BIMS (Brief Interview for Mental Status) of 14, indicating that the resident was cognitively intact. Further review revealed that the resident required the assistance from a staff member for bed mobility, transfers and toileting. Review of Resident R52's care plan, dated initiated July 28, 2020, revealed that the resident was at risk for falls and that she had a history of multiple falls while at the facility. Interventions included for staff to perform frequent checks in an effort to anticipate the resident's needs, to offer bathroom assistance and to encourage the resident to utilize her callbell. Review of progress notes for Resident R52 revealed a nurses note, dated December 29, 2022, at 6:00	F 0609		

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F 0609 SS=D	Continued from page 25 p.m. which indicated that the resident reported to a nurse that earlier that morning at 6:00 a.m. she fell and was helped back to bed by staff. The resident reported that she tried to get up on her own to go to the bathroom when her leg gave out, she lost her balance and fell. The resident reported that she bumped her head. The nurse completed an assessment at that time and noted that the resident had a bump on the right side of her forehead. The resident was subsequently transferred to the hospital emergency department for further evaluation. Review of hospital discharge documentation revealed that Resident R52 was evaluated for her fall and closed head injury (contusion of forehead) with recommendations to continue to monitor the resident. Review of facility documentation submitted to the Department of Health on December 30, 2022, revealed that on December 29, 2022, Resident R52 reported to a nurse that earlier that morning she fell out of bed and bumped her head. The resident	F 0609		

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F 0609 SS=D	Continued from page 26 reported that a staff member assisted her back into bed and provided a description of that staff person. Upon discovery, the facility initiated an investigation and determined that the fall was not reported by the staff member at the time that the incident occurred. Review of facility documentation related to Resident R52's fall revealed a written statement, dated December 30, 2022, from Employee E14, nurse aide, which indicated that Employee E14 last saw Resident R52 "around 5:00 a.m." and that she was "sleep in bed after AM care." Continued review of facility documentation revealed a summary of camera footage from December 29, 2022, from 5:51 a.m. through 6:50 a.m. which showed that Employee E14 went in and out of Resident R52's room several times during that period. Continued review of facility documentation revealed that the Nursing Home Administrator (NHA) and Director of Nursing (DON) conducted an interview	F 0609		

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F 0609 SS=D	Continued from page 27 with Employee E14 on December 30, 2022, and discussed the camera footage with the employee. Employee E14 denied picking up the resident off the floor and denied knowing anything about a fall. Interview on April 20, 2023, at 2:35 p.m. the NHA confirmed that due to Resident R52's report of the incident, including description of the staff person that assisted her back to bed, as well as forehead contusion, that Employee E14 failed to report a fall as required and was terminated from employment. 28 Pa Code: 201.14 (a) Responsibility of licensee 28 Pa Code: 201.18 (e)(1) Management	F 0609		

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F 0623 SS=E	483.15(c)(3)-(6)(8) Notice Requirements Before Transfer/Discharge §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)	F 0623	-Emergency Transfer log for March sent to Ombudsman on 4/21/23. April log sent on 5/1/23. -March and April Logs reviewed and compared to transfer data in Point Click Care system to ensure accuracy. -Social worker educated to submit logs to Ombudsman by the 15th of each month. Social worker will copy Executive Director on those emails. -Executive Director will audit for timeless and accuracy and report results in QAPI x4	Completion Date: **06/23/2023** Status: **APPROVED** Date: **05/18/2023**

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F 0623 SS=E	Continued from page 29 (A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the	F 0623		

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F 0623 SS=E	Continued from page 30 protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by:	F 0623		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0623 SS=E	Continued from page 31 Based on review of facility policies, clinical record review, and interviews with staff, it was determined that the facility failed to notify the Office of the State Long-Term Care Ombudsman of facility-initiated emergency transfers and discharges as required for six of six records reviewed (Residents R50, R29, R52, R41, R22 and R37). Findings include: Review of facility policy, "Transfer or Discharge Facility-Initiated" dated January 4, 2023, revealed that, "Facility-initiated transfers or discharge require a copy of the Transfer or Discharge Notice be sent to The Office of State Long-Term Care Ombudsman." Continued review revealed, "Copies of notices for emergency transfers must also still be sent to the ombudsman, but they may be sent when practicable, such as in a list of residents on a monthly basis. The Emergency Transfer from Facility Log will be utilized monthly and completed by Social Services or designee for this purpose and sent electronically to the Office of the State	F 0623		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396120	A. BLDG: __00_____ B. WING: _____	04/24/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
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F 0623 SS=E	Continued from page 32 Long-Term Care Ombudsman." Review of progress notes for Resident R50 revealed a nurses note, dated March 16, 2023, at 5:54 p.m. which indicated that the resident had a change in condition, including confusion and hallucinations, and was ordered by the physician to be transferred to a local hospital emergency department for further evaluation. The resident subsequently discharged home after her hospital stay and was not readmitted to the facility. Review of progress notes for Resident R29 revealed a nurses note, dated February 27, 2023, at 4:10 p.m. which indicated that the resident had sustained an acute hip fracture after a fall and was ordered by the physician to be transferred to a local hospital emergency department for further evaluation. Review of progress notes for Resident R52 revealed a nurses note, dated December 29, 2022, at 7:00 p.m. which indicated that the resident had a fall and subsequently developed a raised bruise to her	F 0623		

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F 0623 SS=E	Continued from page 33 forehead. The physician ordered for the resident to be transferred to a local hospital emergency department for further evaluation. Review of progress notes for Resident R41 revealed a nurses note, dated March 10, 2023, at 3:44 p.m. which indicated that the resident was transferred to a local hospital emergency department via 911 due to possible stroke with "right arm flaccid, burning and tingling." Review of progress notes for Resident R22 revealed a nurses note, dated March 25, 2023, at 10:45 p.m. which indicated that the resident had a fall and was ordered by the physician to be transferred to a local hospital emergency department for further evaluation. Review of progress notes for Resident R37 revealed a nurses note, dated January 4, 2023, at 5:47 a.m. which indicated that the resident had a change in condition, including "dark bloody stools" and was ordered by the physician to be transferred to a local	F 0623		

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F 0623 SS=E	Continued from page 34 hospital emergency department for further evaluation. Review of facility documentation, "Emergency Transfers from Facility Log" from December 2022 through March 2023 revealed that Residents R50, R29, R52, R41, R22 and R37 were listed on the logs as being emergently transferred to the hospital. Continued review revealed that in December 2022, there were a total of three facility-initiated emergency transfers; in January 2023, there were a total of six facility-initiated emergency transfers; in February 2023, there were a total of six facility-initiated emergency transfers; and in March 2023, there were a total of eight facility-initiated emergency transfers. Further review revealed that there was no indication that the Office of the State Long-Term Care Ombudsman was notified of the above facility-initiated emergency transfers until the information was requested by surveyors on April	F 0623		

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F 0623 SS=E	Continued from page 35 21, 2023. Interview on April 21, 2023, at 12:16 p.m. the Nursing Home Administrator confirmed that the Office of the State Long-Term Care Ombudsman was not notified in a timely manner as required of facility-initiated emergency transfers and discharges. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(2) Management	F 0623		
F 0656 SS=D		F 0656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0656 SS=D	Continued from page 36 483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future	F 0656	-Careplans for R40 and R44 updated to reflect device to prevent hand contractures (R40) and urinary indwelling catheter (R44). -Nursing Management to review careplans of all residents to ensure devices are appropriately noted and careplanned. -Licensed nurses and rehab staff (85%) to be educated regarding process for documenting and implementing therapy recommendations. Licensed nurses (85%) to be educated regarding ensuring devices are appropriately care planned. -DON/ADON will audit monthly to ensure therapy recommendations have been documented and implemented and that devices are appropriately care planned and results will be presented in QAPI x4	Completion Date: **06/23/2023** Status: **APPROVED** Date: **05/18/2023**

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F 0656 SS=D	Continued from page 37 discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by:	F 0656		

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F 0656 SS=D	Continued from page 38 Based on review of clinical record and staff interviews, it was determined that the facility failed to develop a comprehensive care plan related to a urinary indwelling catheter and device to prevent hand contractures for two of 20 residents reviewed (Resident R40 and R44). Findings included: Review of Resident R44's clinical record revealed the resident was admitted on March 14, 2023, with a diagnosis that included retention of urine, encounter for fitting and adjustment of urinary device. A review of an admission progress note dated, March 14, 2023 recorded that the resident arrived with a "16 fr (French) foley cath (catheter) in place draining 100cc tea color urine." Observations of Resident R44 on April 19, 2023, at 2:02 p.m.; April 20, 2023, at 9:49 a.m.; and April 21, 2023, at 9:37 a.m.; revealed the resident had a	F 0656		

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F 0656 SS=D	Continued from page 39 urinary indwelling catheter in place. Review of Resident R44's current plan of care revealed no care plan with interventions related to the care of a foley catheter. Interview on April 21, 2023, at 9:37 a.m. with the Director of Nursing (DON) confirmed that Resident R44 had a foley catheter and there was no care plan developed. Review of Resident 40's clinical record revealed admission on September 28, 2022, with a diagnosis that included rheumatoid arthritis (primarily affects the joints), and muscle weakness. An Admission Minimum Data Set assessment (MDS)- a federally mandated standardized assessment process conducted at specific intervals to plan resident care) dated, February 22, 2023, revealed, the resident required one staff member physical assist for bed mobility, transfer, dressing, personal hygiene, and toilet use. The Brief Interview for Mental Status (BIMS) indicated that the resident's cognition was	F 0656		

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F 0656 SS=D	Continued from page 40 intact. A review of occupational therapy (OT) discharge summary revealed that Resident R40 was discharged from therapy on February 2, 2023 and was recommended restorative nursing program (RNP) to facilitate patient maintaining current level of performance and in order to prevent a decline, development of and instruction in the following RNPs has been completed with IDT: splint or brace Care and eating/self-feeding. A comprehensive care plan revised on September 28, 2022, did not reveal any documentation related to the splint. On April 19, 2023, at 10:49 a.m. an interview with the Resident R40 revealed that he supposed to have a palm protector for his left hand. Resident R40 observed to have contracture as he was sitting in the day room playing a word game with another resident. Resident R40 reported: I supposed to have a brace on left hand, it's somewhere in my room, it's a white color.	F 0656		

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F 0656 SS=D	Continued from page 41 On April 20, 2023, ad 9:52 a.m. Resident R40 observed to be in the day room without the palm protector. On April 20, 2023, at 9:52 a. m. an interview was held with Therapy Director, Employee E12, who confirmed that Resident R40 received occupational therapy and was discharged on February 22, 2023, with recommendation to received RNP program to prevent contractures. His OT therapist recommended for Resident R40 to wear " left palm protector at night 8- to 10 hours as tolerated. Day time use at patient request. To prevent skin breakdown in palm". Therapist Director, Employee E12 further reported that Resident did not agree to wear the palm protector during the night, therefore R40 agreed to wear it during the day. On April 20, 2023, at 2:37 p.m. an interview with Director of Nursing and Administrator was held who confirmed that there was no care plan that had been developed for Resident R40's restorative nursing program.	F 0656		

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F 0656 SS=D	Continued from page 42 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 211.11(a) Resident care plan 28 Pa. Code 211.12(d)(3)(5) Nursing services	F 0656		
F 0658 SS=G		F 0658		

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F 0658 SS=G	Continued from page 43 483.21(b)(3)(i) Services Provided Meet Professional Standards §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by:	F 0658	-E9 was counseled regarding completing the appropriate assessment and documentation following an incident/accident. E15 was terminated. -DON/ADON to review 100% of incident reports for past 12 months to ensure proper assessment and documentation has been done. -Licensed nurse staff to be re-educated on standard of assessing residents after an incident/accident and appropriate documentation. DON/ADON will continue to review 100% of incident reports weekly to ensure proper assessment and documentation has been done. -DON/ADON will audit monthly and results will be reported in QAPI x4	Completion Date: **06/23/2023** Status: **APPROVED** Date: **05/18/2023**

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F 0658 SS=G	Continued from page 44 Based on clinical record review, review of personnel files, review of facility documentation and interviews with staff, it was determined that the facility failed to ensure that a Licensed Practical Nurse and a Registered Nurse, maintained professional standards of quality care in the implementation and evaluation of nursing care using focused assessment and communication with the health care team members as set forth in the Pennsylvania Code Title 49, Professional and Vocational Standards. This failure resulted in actual harm to a resident related to a lack of a timely nursing assessment and a delay of medical care to a resident who sustained a fall which resulted in fracture of left hip which required medical intervention for one of 17 residents reviewed (Resident R29). Findings include: Review of the Pennsylvania Code Title 49, Professional and Vocational Standards, State Board of Nursing 21.11(a)(1)(2)(4) indicated that the Registered Nurse was responsible for collect	F 0658		

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F 0658 SS=G	Continued from page 45 complete and ongoing data to determine nursignc are needs, analyze the health status of individuals and comare the datat with the norm norm when determining care needs and carrying out nursing care actions that promote, maintain and restore the well-being of individuals. Review of the Pennsylvania Code Title 49, Professional and Vocational Standards, Chapter 21.145 Functions of the LPN (Licensed Practical Nurse) revealed, "The LPN is prepared to function as a member of the health-care team by exercising sound nursing judgement based on preparation, knowledge, experience in nursing and competency. The LPN participates in the planning, implementation and evaluation of nursing care using focused assessment in settings where nursing takes place." Continued review revealed, "An LPN shall communicate with a licensed professional nurse and the patient's health care team members to seek guidance when ... the patient's condition deteriorates or there is a significant change in condition, the patient is not responding to therapy, the patient	F 0658		

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F 0658 SS=G	Continued from page 46 becomes unstable, or the patient needs immediate assistance." Review of Licensed Practical Nurse, Employee E9's personnel file revealed a "Licensed Practical Nurse Position Description" signed and dated by the Employee E9 on June 4, 2021, which indicated that essential job duties included ensuring that "documents resident's progress, deterioration, changes in condition etc., as necessary" Continued review revealed that, "abides by both institutional and State Board of Nursing Examiners requirements in the performing of all duties". Review of Registered Nurse, Employee E15's personnel file revealed a "Registered Nurse Shift Supervisor" job description, signed and dated by the Registered Nurse Supervisor, Employee E15 on March 31, 2023, which indicated that essential job duties included, "Investigates all incidents of unknown origin and other incidents" and "monitors nursing care for accurate assessment and appropriate interventions; supervises the care given	F 0658		

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F 0658 SS=G	Continued from page 47 to residents on assigned shift." Review of Resident R29's clinical record revealed that the resident was admitted to the facility on December 19, 2020, with the diagnoses of left femur (hip) fracture, Alzheimer's disease (causes the brain to shrink and brain cells to eventually die), dementia (usually progressive condition marked by the development of multiple cognitive deficits such as memory impairment) with severity and behavioral disturbance, muscle weakness, history of falling. Review of Resident R29's fall assessment, dated December 26, 2022, revealed that the resident was considered a moderate risk for falls. The interventions recommended included a "low bed, non-skid footwear, frequent checks, sit in visualization of staff, broad chair, chair locked." Review of Resident R29's quarterly Minimum Data Set (MDS- assessment of resident's care needs) dated February 3, 2023, revealed that the resident had a BIMS (Brief Interview of Mental Status)	F 0658		

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PHOEBE WYNCOTE STATE LICENSE NUMBER: 232102	208 FERNBROOK AVENUE WYNCOTE, PA 19095

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F 0658 SS=G	Continued from page 48 score of 3 which indicated that the resident was cognitively impaired. Continued review of the MDS revealed that the resident required extensive assistance for bed mobility and limited assistance with transfers and ambulation of one person. Review of Resident R29's care plan, dated February 6, 2023, revealed that the resident had a history of falls/injury and was unaware of safety need. The interventions developed included half side rails to bed as enablers, encourage and assist to participate in activities or social settings that minimize the potential for falls, ensure that resident was wearing appropriate footwear while out of bed and provide slipper socks or non-skid slippers as indicated for nighttime and hourly checks. Review of nursing note dated February 26, 2023 at 7:00 a.m. revealed "CNA (nurse aide) called to nurse resident observed laying on floor next to her bed with blankets over her, no s/s (signs and symptoms) of injury, no c/o (complaint) pain. Resident assisted back to bed. Nsg (nursing)_	F 0658		

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F 0658 SS=G	Continued from page 49 supervisor made aware." Review of the next available nursing note dated February 26, 2023, at 1:02 p.m. revealed "Resident cried out in pain during assessment of lower extremities. Assessment revealed visually swollen b/l (bilateral) knees, R. (right) L (left), no bruising or erythema noted. Resident medicated for pain." The resident's physician was contacted and orders were obtained for X-ray to bilateral knees and left hip. Continued review of nursing documentation dated February 27, 2023, at 4:10 p.m. noted that the results of the X-ray revealed left hip with acute fracture of the subcaptial left femoral (hip) neck. Orders were obtained for the resident to be transferred to the local hospital for evaluation. Review of nursing documentation dated March 1, 2023, revealed that the resident's daughter was informed that after investigation, the facility determined that the resident had a fall in her room that caused her hip fracture.	F 0658		

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F 0658 SS=G	Continued from page 50 Review of physician's notes dated March 6, 2023, revealed that the resident was re-admitted to the facility after "a fall resulting in left femoral neck fractures. She had a left total hip replacement done on February 28, 2023." Review of a witness statement, by Nurse aide, Employee E11, dated February 27, 2023, revealed "I was doing my rounds and I heard someone screaming and I stopped to listen I didn't hear anything so I kept on to the next room so when I came out the room I heard screaming again but this time the nurse was out in the hall and I asked her did she hear so we start looking for where the noise was coming from so the nurse went into [Resident R29] room ... she was laying on the floor with both blankets and her baby on top of her so I start helping her up the nurse start helping me so when I try to put her all the way in the bed she start screaming more so I said of the nurse walk out the room told the nurse supervisor so I got [Resident R29] back in bed."	F 0658		

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F 0658 SS=G	Continued from page 51 Review of a witness statement dated February 27, 2023, by Licensed Practical Nurse, Employee E9, revealed "It was around 5:00 a.m. we both went into the room; it looked like [Resident R29] may have either gotten twisted up and fell from the bed or got up to walk and got twisted. [Resident R29] does get up at night to wonder into other people's room and we have to re-direct her ...I did ROM (range of motion) of her legs and then she said something about her arm. I lifted up her gown to see if I could see anything unusual and did passage ROM of her arm, because she was agitated that I was touching her at all, which can be her usual behavior. Then I went to [Registered Nurse Supervisor, Employee E15] I told the [Registered Nurse Supervisor, Employee E15] [Resident R29] was on the floor holding her doll and with her blanket on top of her. [Registered Nurse Supervisor, Employee E15] said "were not going to consider that a fall." I went back to [Resident R29's] room and told CNA (nurse aide) that we're going to get her up and put her in the bed. [Registered Nurse	F 0658		

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F 0658 SS=G	Continued from page 52 Supervisor, Employee E15] did not visit the [Resident R29]. Review a witness statement, dated February 27, 2023, by Nursing Supervisor, Employee E15, revealed "I regret that I did not immediately get up and assess the situation keeping in mind that Resident R29 was confused and may have fallen. My thinking was that she was resting and not getting up wondering through the hall and going into other residents rooms.' On April 20, 2023, at 2:23 p.m. an interview was held with Nursing Home Administrator (NHA) and Director of Nursing (DON) who reported that based on the video footage, RN Supervisor Employee E15 did not go into the resident's room to assess the resident and failed to report the incident, investigate the allegation, and make any documentation in the clinical report of Resident R29. Registered Nurse, Supervisor, Employee E15 was terminated.	F 0658		

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F 0658 SS=G	Continued from page 53 Review of documentation by the facility, revealed that Licensed nurse, Employee E9 and CNA, Employee E11 found Resident R29 on her floor on February 26, 2023, approximately at 5:00 a.m. Based on the facility investigation the unwitnessed fall was communicated to the RN, Supervisor Employee E15 who failed to assess the resident, failed to investigate, and document the incident. Resident R29 fell and sustained significant injury of an acute fracture of the sub capital left femoral beck with proximal migration of the distal fragment with no dislocation which required a medical intervention a surgery. Licensed nurse, Employee E9 and Registered Nurse, Supervisor Employee E15 failed to document an unwitnessed fall, investigate the incident which delayed medical treatment from 5:00 a.m. to 1:00 p.m. on February 26, 2023, which resulted in Resident R29 being neglected. Therefore, allegation of neglect is substantiated against Licensed nurse, Employee E9 and Registered Nurse, Supervisor Employee E15 Interview on March 15, 2023, at 9:15 a.m. the	F 0658		

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F 0658 SS=G	Continued from page 54 Nursing Home Administrator (NHA) confirmed that RN Supervisor, Employee E15 was terminated for neglect related to not reporting and investigating an unwitnessed fall for Resident R29. Licensed Practical Nurse, Employee E9, failed to maintain professional standards of quality care in the implementation and evaluation of nursing care using focused assessment and communication with the health care team members when Resident R29 had a unwitnessed fall as set forth in the Pennsylvania Code Title 49, Professional and Vocational Standards. which resulted in harm to the resident related to a lack of a timely nursing assessment and a delay of medical care to the resident. Registered Nurse Supervisor, Employee E15 failed to maintain professional standards of quality care, established by essential job requirements, to completed an assessment of Resident R29 after receiving a report of an unwitnessed, investigate the accident, and changes in resident condition as set forth by Chapter 21.1 Practice of professional	F 0658		

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F 0658 SS=G	Continued from page 55 nursing. This failure resulted in actual harm to Resident R29 related to a lack of timely nursing assesment and a delay on medical care to the resident. Refer to F600 and F684. 28 Pa. Code 201.18 (b)(1)(e)(1) Management 28 Pa. Code 211.5(h)Clinical records 28 Pa. Code 211.11(d) Resident care policies 28 Pa. Code 211.12(c) Nursing services 28 Pa. Code 211.12(d)(1)(3) Nursing services 28 Pa. Code 211.12(d)(3) Nursing services 28 Pa. Code 211.12(d)(5) Nursing services	F 0658		

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F 0658 SS=G	Continued from page 56	F 0658		

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F 0658 SS=G	Continued from page 57	F 0658		
F 0684 SS=G		F 0684		

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F 0684 SS=G	Continued from page 58 483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by:	F 0684	-Upon learning of fall and xray results, resident was transferred to hospital. E9 was appropriate counseled regarding assessment standards and documentation. E15 was terminated. -DON/ADON to review incident reports for past 12 months to ensure proper assessment and documentation done. -Directed In-Service to be conducted by Sophie Campbell (scampbell@padona.com) regarding timely assessment and medical intervention following incidents of falls. DON/ADON will continue to review incident reports to ensure proper assessment and documentation has been done. -DON/ADON will audit monthly and results will be reported in QAPI x4	Completion Date: 06/23/2023 Status: APPROVED Date: 05/18/2023

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F 0684 SS=G	Continued from page 59 Based on clinical record review, staff interview and review of facility documentation, it was determined that the facility failed to ensure that a resident received treatment and care in accordance with professional standards of practice by not having a Registered Nurse assess Resident R29 following an unwitnessed fall causing undue pain and a delay in care and treatment. Resident R29 did not have an x-ray report read until 23 hours and 10 minutes from the initial fall for one of 20 residents reviewed. The lack of assessment caused actual harm, undue pain and delay in care to Resident R29 who was diagnosed with a left femoral neck fracture, for one of 17 residents reviewed. (Resident R29) Findings include: Review of Resident R29's clinical record revealed that the resident was admitted to the facility on December 19, 2020, with the diagnoses of left femur (hip) fracture, Alzheimer's disease (causes the brain to shrink and brain cells to eventually die), dementia (usually progressive condition marked by	F 0684		

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F 0684 SS=G	Continued from page 60 the development of multiple cognitive deficits such as memory impairment) with severity and behavioral disturbance, muscle weakness, history of falling. Review of Resident R29's fall assessment, dated December 26, 2022, revealed that the resident was considered a moderate risk for falls. The interventions recommended included a "low bed, non-skid footwear, frequent checks, sit in visualization of staff, broad chair, chair locked." Review of Resident R29's quarterly Minimum Data Set (MDS- assessment of resident's care needs) dated February 3, 2023, revealed that the resident had a BIMS (Brief Interview of Mental Status) score of 3 which indicated that the resident was cognitively impaired. Continued review of the MDS revealed that the resident required extensive assistance for bed mobility and limited assistance with transfers and ambulation of one person. Review of Resident R29's care plan, dated February 6, 2023, revealed that the resident had	F 0684		

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F 0684 SS=G	Continued from page 61 history of falls/injury and was unaware of safety need. The interventions developed included half side rails to bed as enablers, encourage and assist to participate in activities or social settings that minimize the potential for falls, ensure that resident was wearing appropriate footwear while out of bed and provide slipper socks or non-skid slippers as indicated for nighttime and hourly checks. Review of nursing note dated February 26, 2023 at 7:00 a.m. revealed "CNA (nurse aide) called to nurse resident observed laying on floor next to her bed with blankets over her, no s/s (signs and symptoms) of injury, no c/o (complaint) pain. Resident assisted back to bed. Nsg (nursing)_ supervisor made aware." Review of a Nursing note dated February 26, 2023 at 1:02 p.m. revealed: "Resident moaning, pointing to left inner thigh, stating 'it hurts'. Resident cried out in pain during assessment of lower extremities. Assessment revealed visually swollen b/l knees, R>L [right greater than left], no bruising or erythema	F 0684		

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F 0684 SS=G	Continued from page 62 noted. Resident medicated for pain asper PRN order an lidocaine patches placed to b/l knee with some relief noted. Call out to [Doctor's Office], spoke with on call physician ... Order given, readback and verified for X-Ray to B/L knee and Left hip. Resident resting comfortably in chair, will continue to monitor." Continued review of nursing documentation dated February 27, 2023, at 4:10 p.m. noted that the results of the X-ray revealed left hip with acute fracture of the subcapital left femoral (hip) neck. Orders were obtained for the resident to be transfer to the local hospital for evaluation. By not having a Registered Nurse assess Resident R29 following an unwitnessed fall caused undue pain and a delay in care and treatment. Resident R29 did not have an x-ray report read until 23 hours and 10 minutes from the initial fall. The lack of assessment caused actual harm, undue pain and delay in care to Resident R29 who was diagnosed with a left femoral neck fracture.	F 0684		

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F 0684 SS=G	Continued from page 63 Review of nursing documentation dated March 1, 2023, revealed that the resident's daughter was informed that after investigation, the facility determined that the resident had a fall in her room that caused her hip fracture. Review of physician's notes dated March 6, 2023, revealed that the resident was re-admitted to the facility after "a fall resulting in left femoral neck fractures. She had a left total hip replacement done on February 28, 2023." Employee E11, Nurse Aide, Witness statement dated February 27, 2023 (11pm-7am) revealed "I was doing my rounds and I hard [heard] someone screaming and I stop to listen I didn't hear anything so I kept on to the net [next] room so when I came out the room I hard [heard] screaming again but this time the nurse was out in the hall and I ask her did she hear so we start looking for where the noise was coming from so the	F 0684		

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F 0684 SS=G	Continued from page 64 nurse whent [sic - went] in [Resident R29] room and i was right behind her at the same time she was laying on the floor with both blankets and her baby on top of her so I start helping her up the nurse start helping me so when I try to put her all the way in the bed she start screaming more so I said your going to have to send her out she said ok the nurse walk out the room told the nurse supervision so I got [Resident R29] back in bed i finish my work so the next night well that night when i came in the nurse came to me and ask can I put [Resident R29] in bed because x Ray was about to come for her but never did and no i didn't say anything to the next shift i thought everyone knew because they said xray was coming." Review of a witness statement, dated February 27, 2023, by Nursing Supervisor, Employee E15, revealed "I regret that I did not immediately get up and assess the situation keeping in mind that Resident R29 was confused and may have fallen. My thinking was that she was resting and not getting	F 0684		

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F 0684 SS=G	Continued from page 65 up wondering through the hall and going into other residents rooms." The Registered Nurse Supervisor not assessing the Resident after a fall for possible injuries and as a result facility staff then transferring the resident off the ground to the bed without an assessment from a Registered Nurse for possible injuries, caused the resident to scream out in pain causing harm to the Resident. Interview on April 21, 2023, 1:45 p.m. with nurse aide, Employee E11, confirmed that she was a nurse aide assigned to Resident R29 and that she found Resident R29 wrapped up in a blanket rolled over her floor mattress and screaming for help. The resident bed was in low position, Resident R29 "complaint of her pain in her leg, there was no bleeding, bruising. I told the nurse we need to send her out." Review of a witness statement dated February 27, 2023, by Licensed Practical Nurse, Employee E9,	F 0684		

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	396120	A. BLDG: __00_____ B. WING: _____	04/24/2023

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F 0684 SS=G	Continued from page 66 revealed "It was around 5:00 a.m. we both went into the room; it looked like [Resident R29] may have either gotten twisted up and fell from the bed or got up to walk and got twisted. [Resident R29] does get up at night to wonder into other people's room and we have to re-direct her ...I did ROM of her legs and then she said something about her arm. I lifted up her gown to see if I could see anything unusual and did passage ROM of her arm, because she was agitated that I was touching her at all, which can be her usual behavior. Then I went to [Registered Nurse Supervisor, Employee E15] I told the [Registered Nurse Supervisor, Employee E15] [Resident R29] was on the floor holding her doll and with her blanket on top of her. [Registered Nurse Supervisor, Employee E15] said "were not going to consider that a fall." I went back to [Resident R29's] room and told CNA (nurse aide) that we're going to get her up and put her in the bed. [Registered Nurse Supervisor, Employee E15] did not visit the [Resident R29]. Interview on April 21, 2023, at 10:04 a.m. with	F 0684		

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F 0684 SS=G	Continued from page 67 Licensed Practical Nurse, Employee E9, confirmed that she was a nurse assigned to Resident 29 on night shift of February 25, 2023. Employee E9 confirmed Resident R29 was laying on stomach, and away from the floor mat on the bare floor. That she did a brief assessment and went to Registered Nurse, Supervisor, Employee R15. "I advised her that Resident R29 was found on the floor. The RN Supervisor, Employee E15 told me that we're not doing an incident report. I went back to ROM of upper extremity/lower extremity arms and leg and lifted her up to standings position and transferred her to bed. I cannot give an explanation why there's no documentation in the resident's clinical record. I did not notify the coming nurse of the possible unwitnessed fall." Review a witness statement, dated February 27, 2023, by Nursing Supervisor, Employee E15, revealed "I regret that I did not immediately get up and assess the situation keeping in mind that Resident R29 was confused and may have fallen. My thinking was that she was resting and not getting	F 0684		

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F 0684 SS=G	Continued from page 68 up wondering through the hall and going into other residents rooms." The facility failed to ensure that a resident received treatment and care in accordance with professional standards of practice by not having a Registered Nurse assess Resident R29 following an unwitnessed fall causing undue pain and a delay in care and treatment. Resident R29 did not have an x-ray report read until 23 hours and 10 minutes from the initial fall. The lack of assessment caused actual harm, undue pain and delay in care to Resident R29 who was diagnosed with a left femoral neck fracture. Refer to F600 and F658. 28 Pa. Code 201.18 (b)(1)(e)(1) Management 28 Pa. Code 211.5(h)Clinical records 28 Pa. Code 211.11(d) Resident care policies	F 0684		

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F 0684 SS=G	Continued from page 69 28 Pa. Code 211.12(c) Nursing services 28 Pa. Code 211.12(d)(1)(3) Nursing services 28 Pa. Code 211.12(d)(3) Nursing services 28 Pa. Code 211.12(d)(5) Nursing services	F 0684		

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F 0684 SS=G	Continued from page 70	F 0684		
F 0688 SS=D	483.25(c)(1)-(3) Increase/Prevent Decrease in ROM/Mobility §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by:	F 0688	-Splint for R40 is being placed per OT recommendations. Splint has been careplanned. -DON/ADON reviewing all residents on RNP to ensure program is in place. -Licensed nurse and Rehab staff to be educated on system that will ensure therapy recommendations are in place. -DON/ADON will audit monthly and results will be presented in QAPI x4.	Completion Date: **06/23/2023** Status: **APPROVED** Date: **05/18/2023**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0688 SS=D	Continued from page 71 Based on [illegible]	F 0688		
F 0690 SS=D	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and	F 0690	-R44 was placed on void trial and appropriate follow up with urology scheduled to determine diagnosis and any further needed treatment. Physician order obtained for catheter. -All residents with urinary catheters are being review for presence of order, appropriate diagnosis and any follow up necessary with urology. -Upon admission and if implements any time during stay resident has urinary catheter, Nursing will ensure appropriate diagnoses, order and any needed follow-up. Licensed Nurse staff will be educated on this. -DON/ADON will audit monthly and results will be presented in QAPI x4	Completion Date: 06/23/2023 Status: APPROVED Date: 05/18/2023

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F 0690 SS=D	Continued from page 72 (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by:	F 0690		

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F 0690 SS=D	Continued from page 73 Based on clinical record review, facility policy review, and staff interview, it was determined the facility failed to ensure that a resident who was admitted to the facility with a urinary catheter was assessed for its removal in a timely manner for one of 19 residents reviewed. (Resident R44) Findings include: Review of facility policy and procedure titled "Urinary Catheter Management," reviewed December 14, 2020, revealed "Urinary catheter insertion is implemented when clinically indicated using the following guidelines: Urinary retention that cannot be medically or surgically corrected and for which alternative therapy is not an option characterized by: a. Documented PVR volumes over 350 milliliters. B. inability to manage the incomplete bladder emptying or urinary retention with intermittent catheterization. C. persistent overflow incontinence , systematic infections and or renal disaccustoming. 2. Contamination of stage 3 or 4 pressure ulcer which has impeded healing. 3.	F 0690		

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F 0690 SS=D	Continued from page 74 Terminal illness or severe impairment which makes positioning or clothing change painful." Review of Resident 44's clinical record revealed admission on March 14, 2023, with a diagnosis that included retention of urine, encounter for fitting and adjustment of urinary device. Review of Resident R44's current physician orders did not reveal any order for a urinary foley catheter. A Brief Interview for Mental Status (BIMS), dated March 14, 2022, indicated that the resident's cognition was severely impaired. A review of a admission progress note dated, March 14, 2023 recorded that the resident arrived to the facility with a "16fr foley cath in place draining 100cc tea color urine". Observations of Resident R44 on April 19, 2023, at 2:02 p.m.; April 20, 2023, at 9:49 a.m.; and April 21, 2023, at 9:37 a.m.; revealed the resident had a urinary foley catheter.	F 0690		

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F 0690 SS=D	Continued from page 75 Interview conducted with the Director of Nursing (DON) on April 21, 2023, at 9:37 a.m. confirmed that Resident R44 had a urinary foley catheter and there was no other reason in the clinical record to show the necessity of the foley catheter besides the diagnosis of retention of urine. DON confirmed that facility failed to assess the necessity of the urinary foley catheter for Resident R44 nor has not completed a trial for the possible removal of the urinary foley catheter. 28 Pa. Code 211.11(d) Resident care plan 28 Pa. Code 211.10 (d) Resident care policies 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services	F 0690		

Certified End Page

PHOEBE WYNCOTE

STATE LICENSE NUMBER: 232102

SURVEY EXIT DATE: 04/24/2023

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey

Jeane Parisi
Deputy Secretary for Quality Assurance

Debra L. Bogen, MD, FAAP
Acting Secretary of Health

pennsylvania
DEPARTMENT OF HEALTH

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

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